



Quarterly Financial Review (September 2012)

Office of Medicaid Policy & Planning

Office of Medicaid Policy & Planning
Pat Casanova
Director

Unit Directors:
Natalie Angel
Joy Heim
Jeane Maitland

Unit Directors:
Leslie Melton
Kristina Moorhead
Pat Nolting



State of Indiana
Published
September 2012

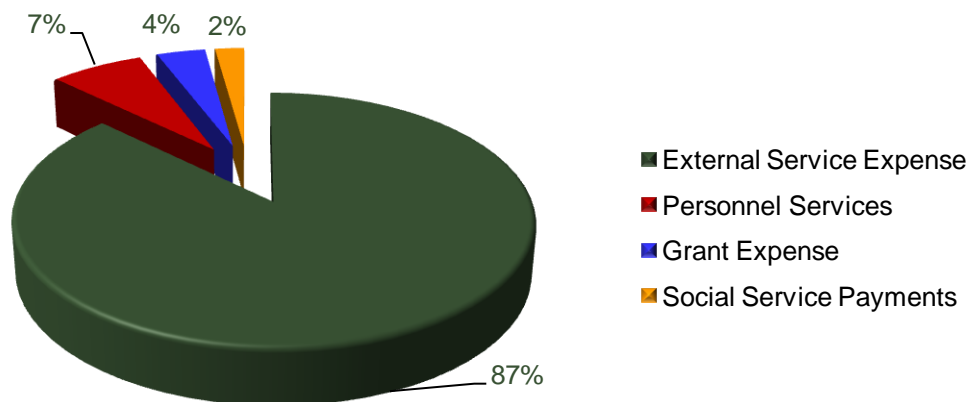


Quarterly Financial Review

- OMPP Financials
 - Medicaid Administration
 - Medicaid Assistance
- Program of All-Inclusive Care for the Elderly (PACE)



Medicaid Administration SFY 2013 Budget

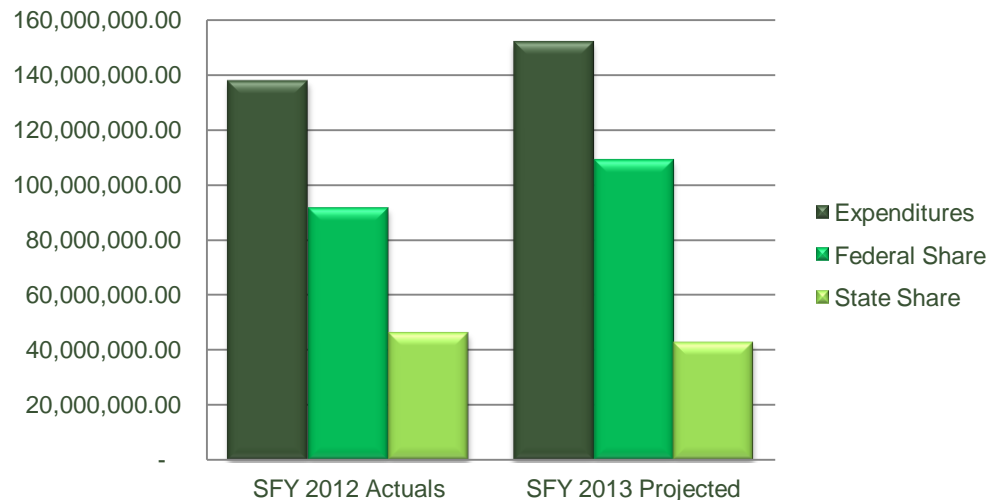


- 87 % of the SFY 2013 Medicaid Admin budget is for budgeted External Services (contracts).
- 13 % of the Medicaid Admin budget is for budgeted personnel, grant and social service spend for SFY2013.

Please note: Supplies, equipment, ID Bills, and miscellaneous admin spend are included in the budget. However the combination of these four categories of spend comprise less than 1% of the actual budget.



Medicaid Administration Yearly Comparison



Year	Expenditures	Federal Share	State Share
SFY 2012 Actuals	137,921,895	91,757,789	46,164,106
SFY 2013 budgeted	151,926,065	109,116,449	42,809,616
Increase/Decrease	10%	19%	-7.27%

- 10% increase in spend budgeted
- Increase due primarily to IT projects (Pharmacy Benefit Manager, Data Warehouse, Medicaid Management Information System)
- The IT projects receive an enhanced federal match, thus, although the spend for SFY 2013 is anticipated to increase when compared to SFY 2012, the actual state share is expected to decrease when compared to SFY 2012.



Medicaid Administration Program Summary September 2012 YTD

Expenditures

	SFY 2013 Year To Date		Variance	SFY 2013	
	Actual	Budget		Forecast	Budget
.1 Personnel Services	2,179,176	2,655,501	476,325	10,535,410	10,535,410
.2 Utilities Expenses	-	-	-	-	-
.3 External Services Expense	20,762,004	33,253,101	12,491,097	131,928,065	131,928,065
.4 Supplies Materials Parts	4,452	10,082	5,630	40,000	40,000
.5 Capital	197	2,521	2,324	10,000	10,000
.7 Grant Expense	942,340	1,389,539	447,199	5,512,846	5,512,846
.8 Social Service Payments	638,347	832,082	193,735	3,301,193	3,301,193
.9 Administrative Expense	8,285	25,899	17,614	102,750	102,750
ID Bills	111,573	124,969	13,396	495,801	495,801
Total	24,646,374	38,293,694	13,647,320	151,926,065	151,926,065

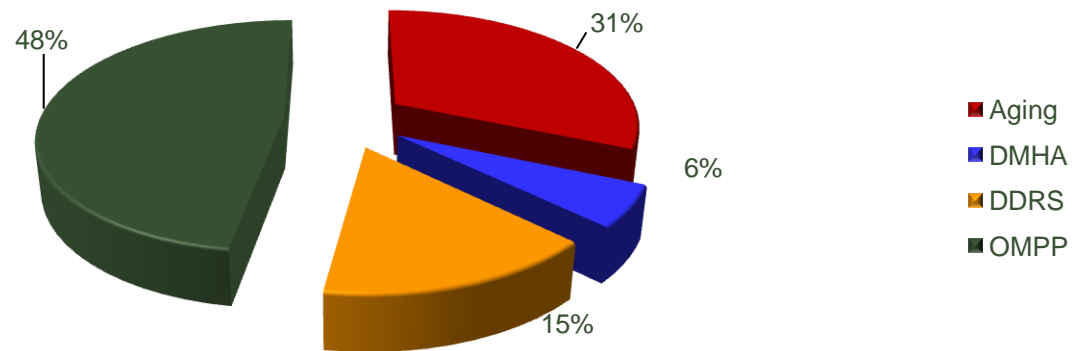
Expenditures

	SFY 2013 Year To Date		Variance	SFY 2013	
	Actual	Budget		Forecast	Budget
Federal	15,687,187	27,503,325	9,826,070	109,116,449	109,116,449
State	8,959,188	10,790,369	3,821,250	42,809,616	42,809,616
Total	24,646,374	38,293,694	13,647,320	151,926,065	151,926,065

•YTD variance due primarily to lag in contract reimbursement



Medicaid Annual Assistance Budget SFY 2013



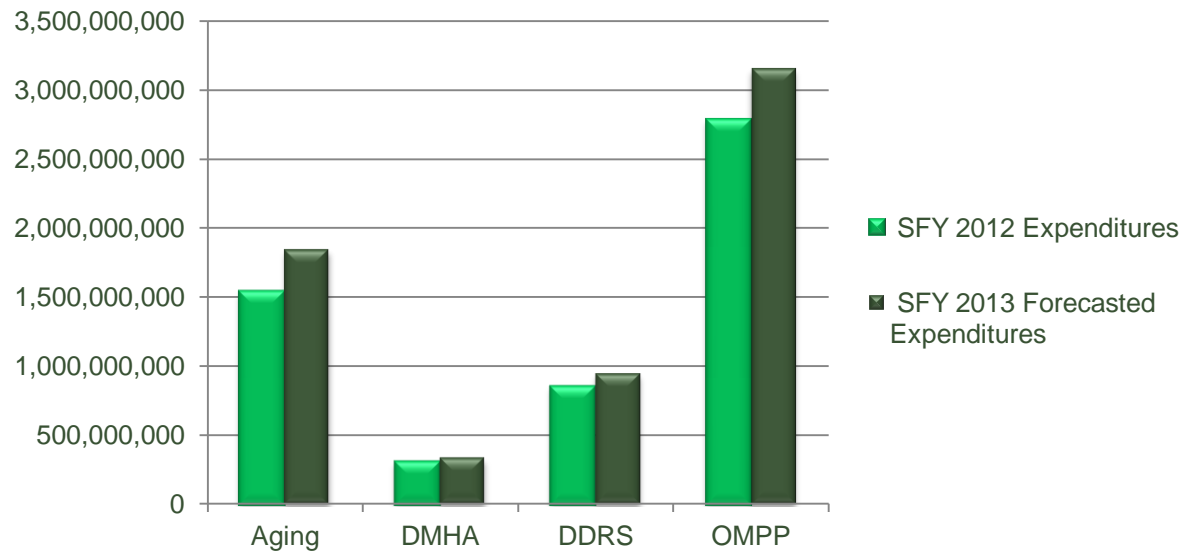
Division	Budget
Aging	1,843,949,020
DMHA	336,893,309
DDRS	948,318,181
OMPP	3,150,723,706

- 48% of SFY 2013 Budget OMPP
- 31% of SFY 2013 Budget Aging
- 15% of SFY 2013 Budget DDRS
- 6% of SFY 2013 Budget DMHA

Note: Budget does not include Hospital Assessment Fee Expenditures.



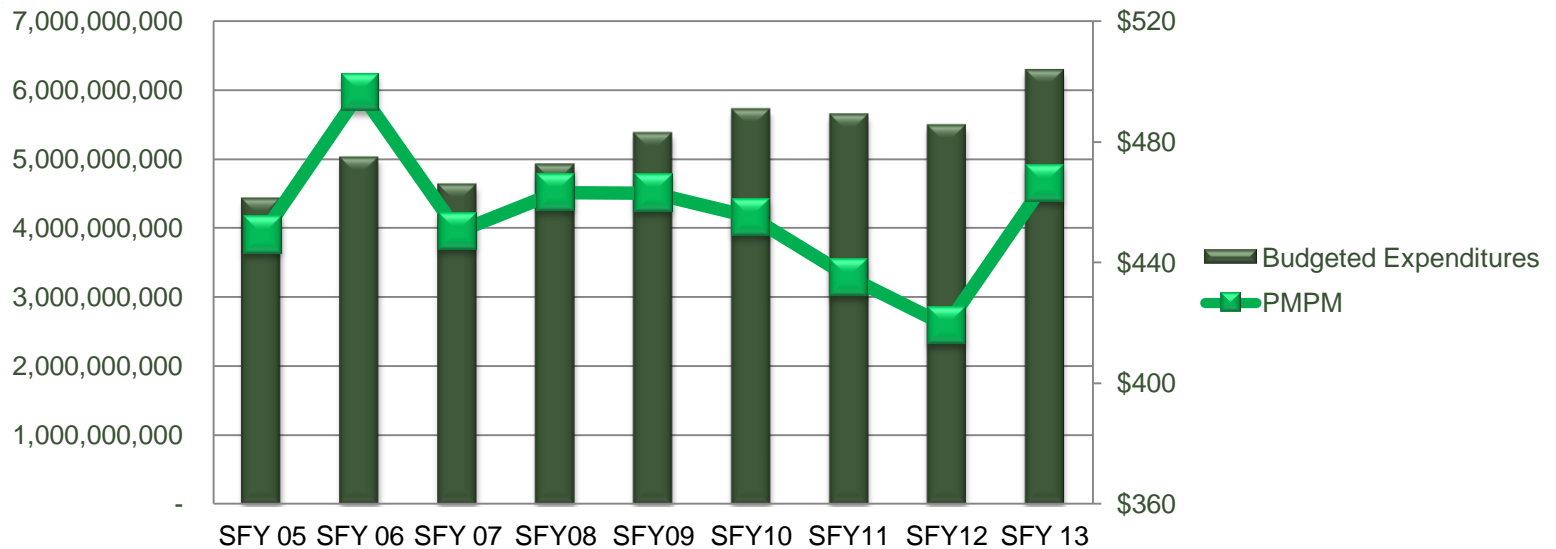
Medicaid Assistance Expenditures - Annual SFY 2012 vs. 2013



Division	SFY 2012 Expenditures	SFY 2013 Forecasted Expenditures
Aging	1,538,204,384	1,843,949,020
DMHA	308,316,366	336,893,309
DDRS	854,921,196	948,318,181
OMPP	2,781,726,008	3,150,723,706
Total - Budgeted Expenditures	5,483,167,954	6,279,884,216



Cost Per Member Per Month SFY 05 -13

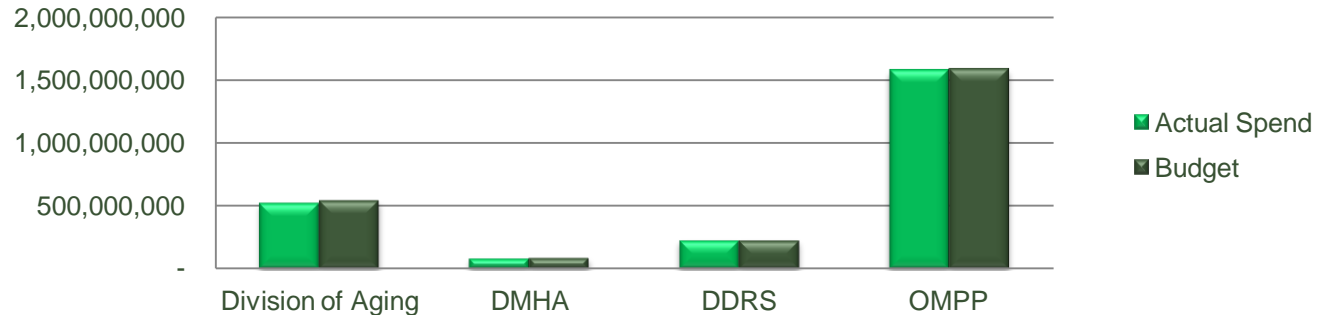


Year	Budgeted Expenditures	PMPM
SFY 05	4,425,462,631	\$449
SFY 06	5,021,345,574	\$496
SFY 07	4,629,408,943	\$450
SFY08	4,919,549,838	\$463
SFY09	5,376,358,891	\$463
SFY10	5,715,625,923	\$455
SFY11	5,640,145,148	\$435
SFY12	5,483,167,954	\$419
SFY 13	6,279,884,215	\$466

Although cost increased through SFY 2010, Cost Per Member Per Month decreased from SFY 09 – SFY 12.



Medicaid Assistance September 2012 YTD Actual Spend vs. Budget

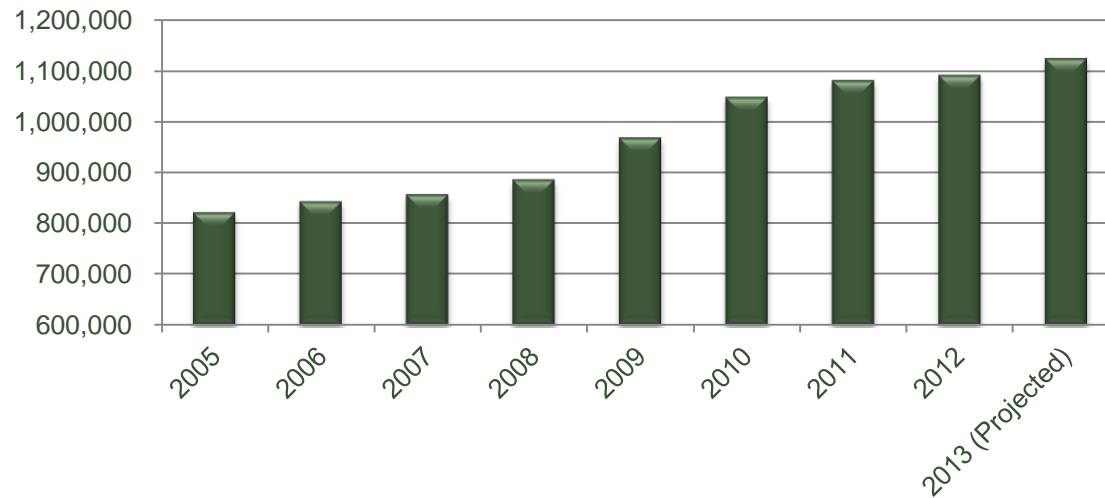


Division	Actual Spend Sept YTD	Budget	Variance
Aging	523,494,798	541,600,340	3.46%
DMHA	84,421,534	87,497,312	3.64%
DDRS	227,630,481	226,856,527	-0.34%
OMPP	1,572,983,236	1,584,636,143	0.74%
Total	2,408,530,049	2,440,590,322	1.33%

DDRS 0.34% over budget, primarily due to CIH Waiver costs.



Enrollment SFY 05 -13



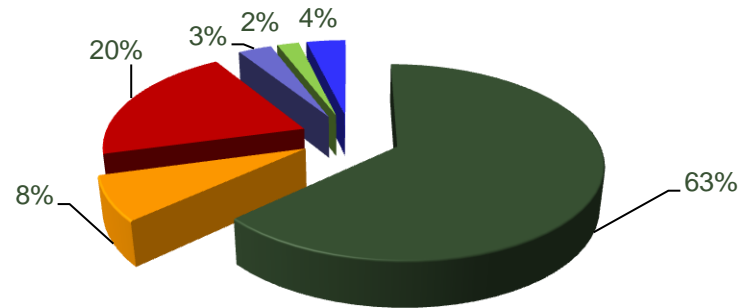
Medicaid continues to see a slight increase in enrollment year after year.

Medicaid Enrollment		
State Fiscal Year	Average Monthly Enrollment	Growth
2005	820,985	
2006	842,870	3%
2007	856,641	2%
2008	884,879	3%
2009	967,475	9%
2010	1,046,513	8%
2011	1,080,185	3%
2012	1,090,235	1%
2013 (budgeted)	1,122,483	3%



Enrollment September 2012 YTD

■ RBMC ■ Traditional ■ Aged, Blind, and Disabled ■ Institutional (NF, Hospice, ICF/ID) ■ Waiver ■ HIP

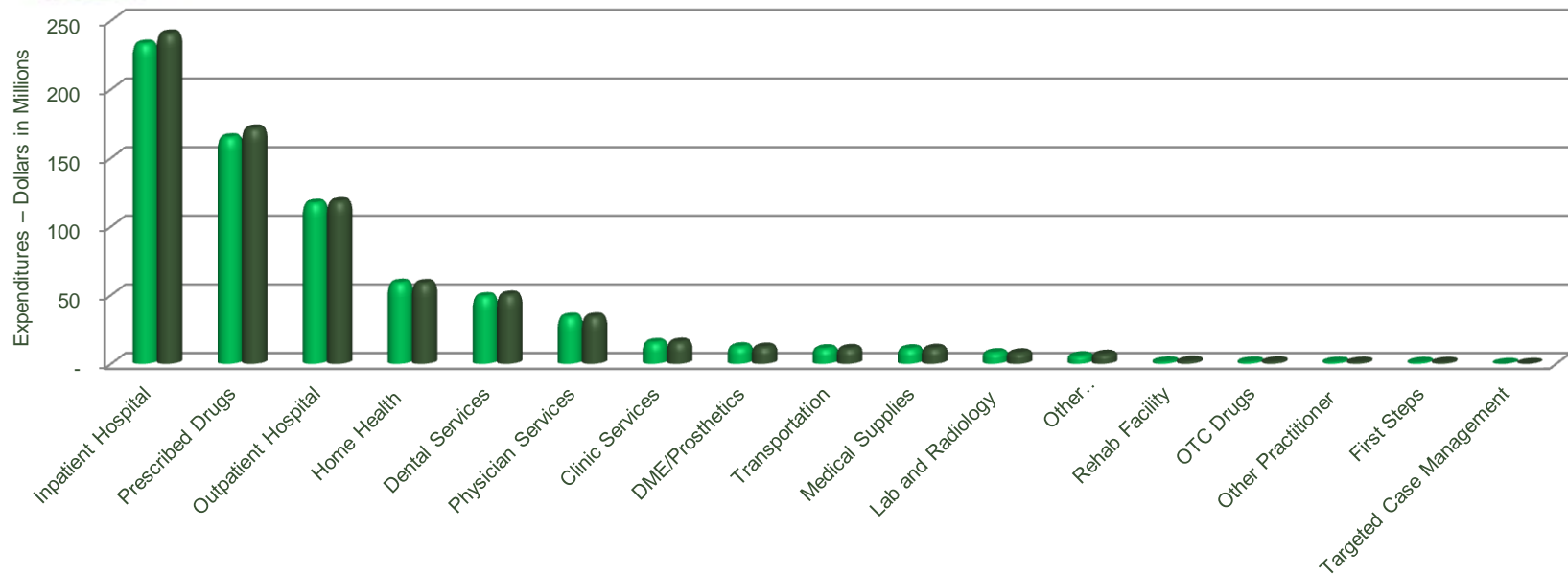


RBMC makes up the largest population in Medicaid at 63%

Category	Enrollment
RBMC	700,177
Traditional	82,632
ABD	224,652
Institutionalized	35,111
Waiver	23,086
HIP	41,413



State Plan Services September 2012 YTD

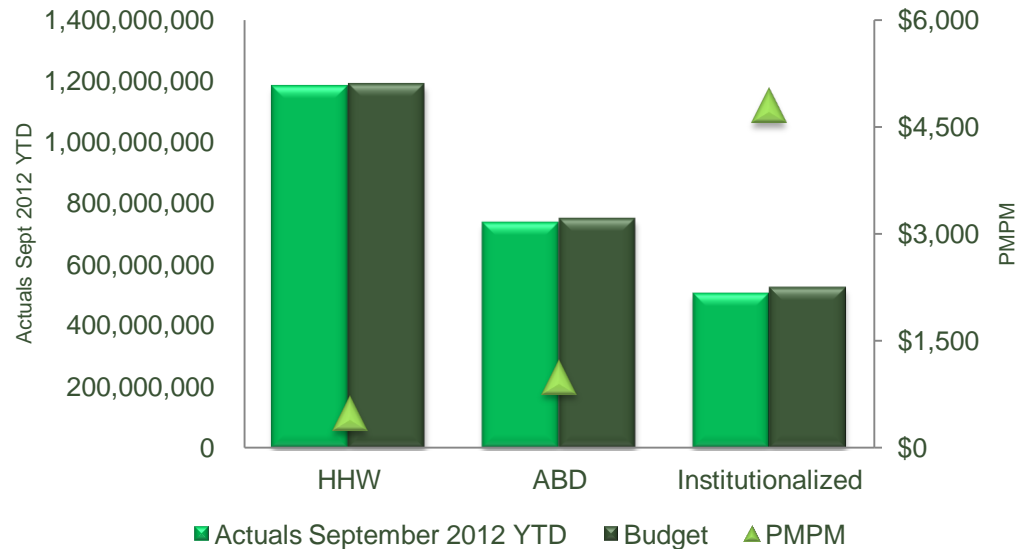


State Plan Services	Inpatient Hospital	Prescribed Drugs	Outpatient Hospital	Home Health	Dental Services	Physician Services	Clinic Services	DME/Prosthetics	Transportation	Medical Supplies	Lab and Radiology	Other Non-Hospital	Rehab Facility	OTC Drugs	Other Practitioner	First Steps
Actual Spend YTD	233	165	117	59	49	34	16	12	11	11	8	6	2	2	1	1
Budget	240	171	118	59	50	34	16	12	11	11	8	7	2	2	1	1
Variance	3%	4%	1%	-0.39%	2%	0%	2%	-2%	1%	3%	-2%	20%	25%	9%	3%	1%

*Note: Dollars in millions



Delivery Systems September 2012 YTD

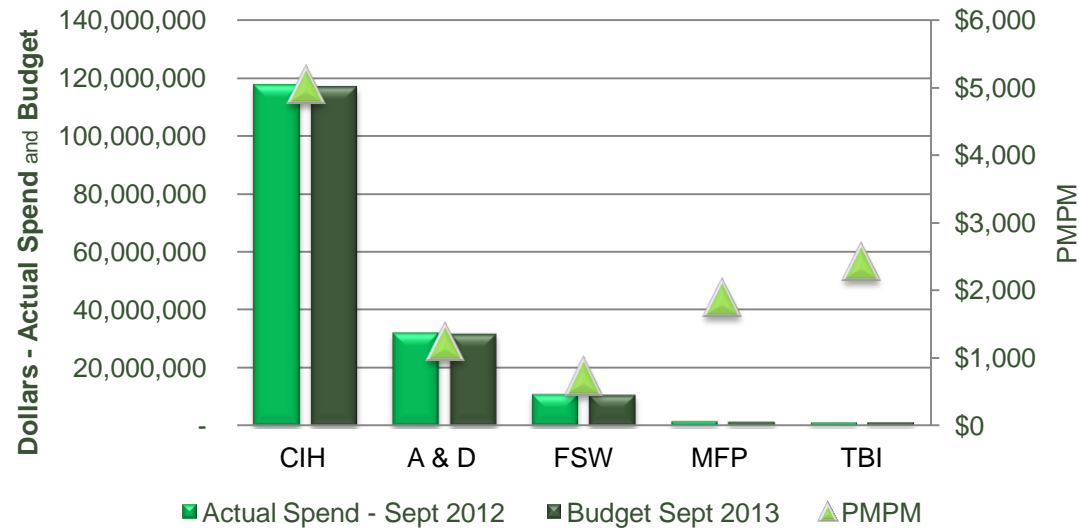


Delivery System	Actuals September 2012 YTD	Budget	PMPM	Enrollment
HHW	1,181,547,954	1,187,663,293	\$477	825,107
ABD	735,903,256	748,873,687	\$992	247,299
Institutionalized	506,108,452	523,999,154	\$4,806	35,105

- Institutionalized population has the lowest recipient count and the highest cost per member.
- HHW has the highest enrollment and lowest cost per member.
- Population Descriptions:
 - Institutionalized Population: Recipients, those with Nursing Facility, Hospice, or ICF/ID level of care.
 - ABD Population: Non-institutionalized Aged, Blind, and Disabled recipients. Also includes Wards and Fosters.
 - HHW Population: TANF and CHIP recipients with no Level of Care, receiving care through Hoosier Healthwise, HIP, or through a Traditional FFS delivery system.



Waivers Services September 2012 YTD



Waiver/Grant	Actual Spend - Sept 2012	Budget Sept 2013	PMPM
CIH	117,711,634	116,860,100	\$5,044
A & D	32,297,342	31,826,375	\$1,235
FSW	11,104,028	10,721,245	\$715
MFP	1,614,610	1,523,227	\$1,882
TBI	1,258,303	1,282,710	\$2,411

CIH, A & D, FSW, and MFP waivers have exceed projections. This is primarily due to higher than budgeted cost per enrollee.

Note: Expenditures are for waiver services only. Does not include any State Plan Services.



State Plan Services Variance Explanations

State Plan Services	Actual Spend YTD	Budget	Variance	Variance Explanation
Nursing Facility	374,929,093	390,691,318	4.2%	Favorable variance attributable primarily to lower utilization then budgeted. Additionally, the budget included anticipated July 1, 2012 rate increase. These rate increases have not been finalized.
Hospice	21,719,265	21,938,561	1.0%	Favorable variance attributable primarily to lower enrollment then budgeted. The budgeted assumed enrollment growth would be at 1.5-2%. As of September, enrollment remains flat.
Aged and Disabled Waiver	32,297,342	31,826,375	-1.5%	Unfavorable variance attributable primarily to higher utilization of waiver services than budgeted. Waiver cost per enrollee is showing at 2.7% higher than budgeted.
MFP Demonstration Grant	1,614,610	1,523,227	-5.7%	Unfavorable variance attributable primarily to higher utilization of waiver services than budgeted. Enrollment is higher than budgeted. Waiver cost per enrollee is 5% higher than budgeted.
TBI	1,258,303	1,282,710	1.9%	Favorable variance attributable primarily to lower utilization than budgeted of , primarily of the Attendant Care Services. Waiver cost per enrollee 5% higher than budgeted.
Family Supports	11,104,028	10,721,245	-3.4%	Unfavorable variance attributable primarily to higher utilization of waiver services than budgeted and higher enrollment than budgeted. Cost per enrollee 1.4% higher than budgeted.
CIH Waiver	117,711,634	116,860,100	-0.7%	Unfavorable variance attributable primarily to higher utilization of waiver services than budgeted. Waiver cost per enrollee 2.3% higher than budgeted.
ICF/ID	73,911,239	73,901,430	-0.01%	Unfavorable variance attributable primarily to higher utilization than budgeted in Small Group Homes. Forecast budgeted a 3.8% decrease in spend over 2012, however, we actually seeing an increase.
Inpatient Psychiatric	11,136,219	11,842,606	6.3%	Favorable variance attributable primarily to lower utilization than budgeted, primarily in the ABD Non Duals population.
Mental Health Rehabilitation	51,698,838	53,460,608	3.4%	Favorable variance attributable primarily to lower enrollment than budgeted.



State Plan Services Variance Explanations

State Plan Services	Actual Spend YTD	Budget	Variance	Variance Explanation
Other Mental Health Services	9,089,706	9,067,483	-0.2%	Unfavorable variance attributable primarily to higher utilization than budgeted in Institutionalized population. Estimated recipients is lower than budgeted, however, cost per recipient is higher than budgeted.
PRTF Facility	6,965,421	7,151,576	2.7%	Favorable variance attributable primarily to lower utilization than budgeted. Additionally, enrollment is lower than budgeted.
CA - PRTF	3,796,815	3,722,367	-2.0%	Unfavorable variance attributable primarily higher utilization that budgeted.
Managed Care	907,291,541	907,458,123	0.02%	Favorable variance attributable to: - Lower CAP payments than budgeted. - Lower Kick Payments than budgeted.
Healthy Indiana Plan	71,244,051	73,264,237	2.8%	Favorable variance attributable to: - ESP Payments have not been paid as of Sept 2012 - 39% of Stop Loss remain unpaid - Enrollment is lower than budgeted
Inpatient Hospital	232,972,596	240,446,329	3.2%	Favorable variance attributable primarily to lower utilization, specifically in the ABD population. Lower utilization in the Care Select and Non Duals population make up 99% of the favorable variance.
Outpatient Hospital	117,036,429	118,214,119	1.0%	Favorable variance attributable primarily to lower utilization, specifically in the RBMC population. Lower utilization in the HH Child population makes up 86% of the favorable variance. The remaining favorable variance is seen in the ABD population.
Rehabilitation Facility	1,686,071	2,113,755	25.4%	Favorable variance attributable primarily to lower utilization, specifically in the ABD population. Lower utilization in the Duals population makes up 50% of the favorable variance and another 34% of the favorable variance is seen in the Care Select and Partial Population.
Physician Services	34,131,141	34,197,401	0.2%	Favorable variance attributable primarily to lower utilization than budgeted in the RBMC population.
Lab and Radiology Services	8,110,785	7,965,704	-1.8%	Unfavorable variance attributable primarily to higher utilization than budgeted primarily in the Duals population.



State Plan Services Variance Explanations

State Plan Services	Actual Spend YTD	Budget	Variance	Variance Explanation
Other Practitioner Services	1,406,590	1,450,764	3.1%	Favorable variance due primarily to lower utilization than budgeted. *This category includes all Therapies, Chiropractic, and Podiatrist Services. Therapy expenditures have experienced the largest decline relative to SFY 2012, primarily in Respiratory and Audiology Therapy.
Clinic Services	15,510,259	15,770,919	1.7%	Favorable variance attributable primarily to lower utilization than budgeted in the Institutionalized Population, Nursing Homes specifically, and the Non Duals Population.
DME/Prosthetics	12,429,161	12,166,549	-2.1%	Unfavorable variance attributable primarily Unfavorable variance attributable to higher utilization than budgeted across all populations.
Medical Supplies	10,920,076	11,270,478	3.2%	Favorable variance attributable primarily to lower utilization than budgeted in the primarily in the ABD population, which makes up 99% of the favorable variance.
Transportation	10,969,678	11,133,002	1.5%	Favorable variance attributable primarily to lower utilization than budgeted in all populations, excluding the waivers. Increased utilization primarily in the Wheelchair Van category of transportation.
Other Non-Hospital	5,769,956	6,905,914	19.7%	Favorable variance due primarily to lower utilization than budgeted. *This category includes Freestanding Dialysis, Vision, School Services, and Other. Freestanding dialysis expenditures experienced the largest decline relative to SFY 2012.
Prescribed Drugs	164,845,842	171,188,122	3.8%	80% of the favorable variance is due primarily to lower utilization than budgeted in the ABD population. Of that 80%, Care Select makes up 45% and Non Duals make up an additional 32% of the favorable variance. We are seeing decreases in Non Legend Drug expenditures and Compound Drug expenditures.
OTC Drugs	1,604,584	1,746,347	8.8%	Favorable variance attributable primarily to lower utilization than budgeted in the Institutionalized Population, Nursing Homes specifically, and the ABD Population.



State Plan Services Variance Explanations

State Plan Services	Actual Spend YTD	Budget	Variance	Variance Explanation
Dental Services	48,913,926	50,093,977	2.4%	Favorable variance attributable primarily to lower utilization than budgeted in the RBMC population, primarily in the HH Child category
Home Health Services	58,817,224	58,585,233	-0.4%	Unfavorable variance attributable primarily to: - Higher utilization than budgeted, primarily by waiver population - Increased cost per service than budgeted.
First Steps	1,242,592	1,260,989	1.5%	Favorable variance attributable primarily to lower utilization the budgeted primarily in the ABD Care Select and HH CHIP population.
Pharmacy Rebates	(86,897,257)	(88,936,717)	2.3%	Unfavorable variance attributable primarily timing. Historically, rebate collections are at 95%. For quarter ending 9/30, collections were at 11%.



PROGRAM OF ALL- INCLUSIVE CARE FOR THE ELDERLY (PACE)



What is PACE?

- A Risk-Based Managed Care Medicare/Medicaid Program
- Serves individuals who are age 55 or older
- Certified by their state to need nursing home care
- Are able to live safely in the community, at the time of enrollment
- Live in a PACE service area



PACE Benefits

- Primary Care (doctor & nursing services)
- Hospital Care
- Medical Specialty Services
- Prescription Drugs
- Nursing Home Care
- Emergency Services
- Home Care
- Physical Therapy
- Occupational Therapy
- Adult Day Care
- Recreational therapy
- Meals
- Dentistry
- Nutritional Counseling
- Social Services
- Laboratory/X-ray Services
- Social Work Counseling
- Transportation



Program Administration

A PACE organization is a non-profit private or public entity that is primarily engaged in providing PACE health care services. To qualify as a PACE site, the organization must have:

- A governing board that includes community representation
- A physical site to provide adult day care services
- A defined service area
- The ability to provide the complete service package regardless of frequency or duration of services
- Safeguards against conflict of interest
- Ability to demonstrate fiscal soundness



Beneficiary Application and Enrollment Process

- Enrollment in the PACE program is voluntary.
- If an individual meets the eligibility requirements and elects PACE, then an Enrollment Agreement is signed.
- Enrollment continues
 - as long as desired by the individual, regardless of change in health status,
 - until voluntary disenrollment; or,
 - involuntary disenrollment.



Financing

- PACE organizations are paid monthly prospective payments for each eligible enrolled PACE program participant in accordance with Sections 1853 and 1894(d)(1) of the Social Security Act.
- Obligation for payments is shared by Medicare, Medicaid, and individuals who do not participate in either Medicare or Medicaid.
- The capitation rates paid by Medicaid are designed to result in cost savings relative to expenditures that would otherwise be paid for a comparable nursing facility-eligible population.
- For Medicaid enrollees, the monthly payment is a negotiated, fixed amount regardless of changes in a participant's health status.
- OMPP anticipates that the per member per month capitation payment will be approximately 95% of these costs.
- The PACE organization accepts the capitation payment amounts as payment in full from Medicare and Medicaid.



PACE Timeline

- State Plan Amendment submitted to CMS on 7/20/12, with an effective date of 10/1/12.
- Request for Additional Information received from CMS on 10/1/12.
- Answers to RAI and revised State Plan reimbursement page due to CMS on 12/30/12.



The End